

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 8 Film 6253 12-8-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

13148

13104

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Ocean City, 23x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Holloway Nursing Home</u>				d. STREET ADDRESS <u></u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elza</u> Middle <u>Ayres</u> Last <u></u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?-?-1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Iceplant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mary Mears</u> Address <u>Selbyville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>11/11</u> , 19 <u>59</u> , to <u>11/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/12</u> , 19 <u>59</u> , and that death occurred at <u></u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernst M. Lamm</u> M.D.				ADDRESS (Street, city or town, state) <u>Delmar, Del</u> DATE SIGNED <u>11/14/59</u>			
PHYSICIAN'S NAME (Type) <u>E M LAMM</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>		22b. DATE THEREOF <u>11/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

13105

## CERTIFICATE OF DEATH

Reg. Dist. No.

13090

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>317 E. College Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Mae</b> Last <b>Bergman</b>				4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1911</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas P. Oliver</b>				14. MOTHER'S MAIDEN NAME <b>Ida M. Keohoe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>John H. Bergman</b> Address <b>Riverside Drive Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Abdominal carcinoma</b> 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of ovary</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>3 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>11-5</b> , 19 <b>59</b> , and that death occurred at <b>6:20 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William H. Fisher Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury Md</b> DATE SIGNED <b>11-5-59</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/7/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Wallace Salisbury, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

13102

NAME OF DECEASED		DATE OF DEATH	
JAMES M. WHITE		JANUARY 15, 1912	
AGE		SEX	
65		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTH PLACE		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BIRTH		DATE OF DEATH	
JANUARY 1, 1847		JANUARY 15, 1912	
TIME OF DEATH		PLACE OF DEATH	
10:30 A.M.		HOME	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DISEASE OR INJURY		PREVIOUS ILLNESS	
CORONARY ARTERY DISEASE		NONE	
SYMPTOMS		TREATMENT	
PAIN IN CHEST		NONE	
DURATION OF ILLNESS		DATE OF INTERMENT	
24 HOURS		JANUARY 15, 1912	
NAME OF PHYSICIAN		NAME OF BURIAL PLACE	
J. M. WHITE		CATHOLIC CHURCH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. M. WHITE		J. M. WHITE	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 15, 1912		JANUARY 15, 1912	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13106  
CERTIFICATE OF DEATH

Reg. Dist. No.

13091

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>DAMES QUARTER 19X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>		d. STREET ADDRESS <u>MAIN ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>Bozman</u> Last <u>Bozman</u>		4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-3-1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN S HORES</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH TIGNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Lottie McInturff</u>		Address <u>James Quarter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOVEMBER 15 1959</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>  </u> 19 <u>  </u> , and that death occurred at <u>6:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilman</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u>	
PHYSICIAN'S NAME (Type) <u>David J. Gilman</u>		DATE SIGNED <u>Nov 23 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 24-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Family</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leroy Sweetland</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

CERTIFICATE OF DEATH

13108

FLORENCE

Sept 2-1878

2 H-62

2-18-78

1878

1878



CERTIFICATE OF DEATH

Reg. Dist. No.

13092

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>214</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas W. Wesley Burdette</u>				4. DATE OF DEATH Month Day Year <u>11 29 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/21/79</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Richard Burdette</u>				14. MOTHER'S MAIDEN NAME <u>Laura Watkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> [If yes, give war or dates of service] <u>none</u>				16. SOCIAL SECURITY NO. <u>218 10 9256</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic congestion of lungs</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>  <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4-29-59</u> , to <u>11-29, 1959</u> , that I last saw the deceased alive on <u>11-29-59</u> , 19 <u>59</u> , and that death occurred at <u>6:10 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>11-30-59</u> ACTUAL SIGNATURE <u>L. V. Maldve</u> M.D. <u>Salisbury, Maryland</u> PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Dec. 2, 1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Lothian, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 1 '59</u> DATE			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

13107

REPUBLIC OF CHINA

13107

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13093

13108

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Jane</b> Last <b>Carey</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/29/1884</b>
9. AGE (In years last birthday) yrs. <b>75</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Watson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth T. Merritt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b> (If yes, give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
INFORMANT <b>Deer's Head Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerosis, general</b> DUE TO (c) <b>Years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old cerebral hemorrhage</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 19, 1959</b> to <b>November 6, 1959</b> , that I last saw the deceased alive on <b>November 6, 1959</b> , and that death occurred at <b>8:15 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>11/6/59</b>			
ACTUAL SIGNATURE <b>L. V. Maldve</b>		M.D. <b>Deer's Head State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		<b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11-8-59</b>	
22c. NAME OF CEMETERY <b>Goodwill Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Rural Pocomoke City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>		24a. REC'D BY REGISTRAR <b>NOV 10 '59</b>	
ADDRESS <b>Pocomoke City, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

18109  
CERTIFICATE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G253 12/3/59 1wk

CERTIFICATE OF DEATH

Reg. Dist. No.

13094

13109

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Della</b> Middle <b>Cephas</b> Last <b>Cephas</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/1927</b>
9. AGE (In years last birthday) <b>32</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ernest Watford</b>		14. MOTHER'S MAIDEN NAME <b>Mary Freeman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Deer's Head Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic congestion of lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Hypertensive cardiovascular disease, decompensated.</b> DUE TO (b) <b>?</b> (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 3</b> , 19 <b>59</b> , to <b>Nov. 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 5</b> , 19 <b>59</b> , and that death occurred at <b>4:35A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>V. Juerman</b>		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>11/5/59</b>	
PHYSICIAN'S NAME (Type) <b>W. Juerman, M. D.</b>		<b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11-5-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Betha</b>		22d. LOCATION (City, town, or county) (State) <b>CAMbridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leon W. Henry</b>		ADDRESS <b>CAMbridge Md.</b>	
24a. REC'D BY REGISTRAR <b>Nov 20 59</b>		DATE <b>Nov 20 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

FOLEI<sup>4</sup>

11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 1 D, Film G252, 11/19/59 iwk  
13110  
CERTIFICATE OF DEATH

13095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wico.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>2 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Tony Tank—just out side of Salisbury</b>				d. STREET ADDRESS <b>Tony Tank</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ISABEL</b> Middle <b>THRIG</b> Last <b>CHILDS</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>12</b> Year <b>19 59</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1874</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>David Thrig</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Crandall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Bruce Dean</b> Address <b>, same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage.</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 4, 1959</b> , 19____, to <b>Nov 1959</b> , 19____, that I last saw the deceased alive on <b>Nov 3</b> , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>226 N. Division St. Salisbury, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>Carrie I. Hearn</b> M.D. <b>Carrie I. Hearn</b> PHYSICIAN'S NAME (Type) <b>Carrie I. Hearn, M.D.</b> <b>226 N. Division St. Salisbury, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wooster Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wooster Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur E. Hearn</b> <b>Arthur E. Hearn</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hearn</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13096

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>		c. LENGTH OF STAY IN TB <u>8 Month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Baby</u> Middle <u>Christopher</u> Last <u>Christopher</u>							
<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>27</u> Year <u>1959</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8/8/59</u>			
<b>9. AGE</b> (In years last birthday) <u>—</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>4</u> Days <u>—</u>		<b>IF UNDER 24 HRS.</b> Hours <u>—</u> Min. <u>—</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Florence Christopher</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)			
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mary Christopner</u>		<b>Address</b> <u>Eden, Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>921.0</u> DUE TO <u>Asphyxia of Ventricle</u> Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause lost. DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Asphyxiated Ventricle</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>11 27 1959</u> Hour <u>2</u> a. m. <u>—</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
<b>20f. (City or town)</b> <u>Eden</u>		<b>(County)</b> <u>Wicomico</u>		<b>(State)</b> <u>Md</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Earl L. Royer</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>Earl L. Royer</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>11-27-59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11/28/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Flower Hill</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Eden</u>		<b>(State)</b> <u>Maryland</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William H. James Jr</u>				<b>ADDRESS</b> <u>Princess Anne, Md</u>			
<b>24a. REC'D BY REGISTRAR</b> <u>DEC 2 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hays</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Isaac Lee Conway Jr.</b>		4. DATE OF DEATH <b>11-16-59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-22-37</b>
9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Creosote Plant</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Isaac Lee Conway</b>		14. MOTHER'S MAIDEN NAME <b>Alena Price</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Issac Conway, Quantico, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage-traumatic.</b> <b>823x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>27 hrs.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car that ran off road and overturned.</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:20 P.M. 11-15-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 349</b>		20f. (City or town) (County) (State) <b>Royal Oak, Talbot Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>11-17-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/18/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Head of Creek Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Quantico Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. J. Measitt</b>		ADDRESS <b>Bivalve, Maryland</b>	
24a. REC'D BY REGISTRAR <b>NOV 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



13149

CERTIFICATE OF DEATH

13098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>XXXX</b>				d. STREET ADDRESS <b>Willards</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>William Slidel Cooper</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>21,</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 27, 1884</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Lumberman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Cooper</b>				14. MOTHER'S MAIDEN NAME <b>Rose Jane Stokely</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>217-07-6755</b>		17. INFORMANT <b>Elizabeth Cooper Willards, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertension</b> DUE TO (c) <b>arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>diabetes mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>1957</b> , 19____, to <b>11-21-1959</b> , that I last saw the deceased alive on <b>11-21-1959</b> , 19____, and that death occurred at <b>5 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank Lewis</b>				ADDRESS (Street, city or town, state) <b>Willards, Maryland</b>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cooper</b>		22d. LOCATION (City, town, or county) (State) <b>Willards, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley Selby, Del.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hange</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE		DATE OF DEATH 1918	
NAME OF DECEASED JAMES J. COOBY		SEX Male	
AGE 38		RACE White	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Married		CAUSE OF DEATH Pneumonia	
DATE OF DEATH 1918		PLACE OF DEATH Baltimore, Md.	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF BURIAL PLACE St. Mary's Cemetery	
NAME OF FUNERAL HOME J. H. Smith & Co.		NAME OF MINISTER Rev. J. H. Smith	
NAME OF NEXT OF KIN Mrs. J. H. Smith		NAME OF WITNESS J. H. Smith	
NAME OF REGISTRAR J. H. Smith		NAME OF CLERK J. H. Smith	



## CERTIFICATE OF DEATH

Reg. Dist. No.

13099

13112

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN Ib <b>7 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springhill Private Sanitarium</b>		d. STREET ADDRESS <b>418 West High St.,</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mrs. Ella Crow</b>		4. DATE OF DEATH Month Day Year <b>November 27 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1879</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Israel Woodring</b>		14. MOTHER'S MAIDEN NAME <b>Isabel Yost</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-12-2343</b>	
17. INFORMANT <b>Mrs. Isabel Bilzard</b>		Address <b>Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2 Degenerative Heart Disease</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Unk</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5</b> , 19 <b>59</b> , to <b>Nov. 27</b> , 19 <b>59</b> that I last saw the deceased alive on <b>11-27</b> , 19 <b>59</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wilbur R. Ellis Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>11-27-59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Wilbur R. Ellis, Jr.</b>		<b>Medical Center, Salisbury, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Chestertown, md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Wilbur Wells</b>		24a. REC'D BY REGISTRAR ADDRESS <b>Che stertown, Md</b> DATE <b>DEC 1 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13113

CERTIFICATE OF DEATH

Reg. Dist. No.

13160

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>90 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lauretta</b> Middle <b>Dashiell</b> Last <b>Dashiell</b>				4. DATE OF DEATH Month <b>November</b> Day <b>23</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/27/1891</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>			
13. FATHER'S NAME <b>Elias Polk</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Mull</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>				16. SOCIAL SECURITY NO. <b>217-10-3862</b>			
17. ADDRESS <b>Deer's Head State Hospital</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic congestion of lung</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Recurrent cerebral thrombosis</b> DUE TO (c) <b>Hypertensive arteriosclerotic cardiovascular disease ?</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>14 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyelonephritis, chronic</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August 25</b> , 19 <b>59</b> , to <b>Nov. 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 23</b> , 19 <b>59</b> , and that death occurred at <b>9:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>11/24/59</b>							
ACTUAL SIGNATURE <b>Juerman</b>				M.D. <b>Deer's Head State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-29-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Green Acres Cem</b>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Barbara D. West</b>				ADDRESS			
24a. REC'D BY REGISTRAR DATE <b>DEC 2 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>			

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13113

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13114

13101

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tracy's, Maryland</b> 02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Chester</b> Middle <b>Josiah</b> Last <b>Dorsey</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 11, 1900</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tenant Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Susan Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk/10</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unk</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent Cerebral hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension Arterio Sclerotic Cardio Vascular D.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 12,</b> 19 <b>58</b> to <b>Nov. 28,</b> 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 28,</b> 19 <b>59</b> , and that death occurred at <b>11:55P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. Maldve</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/29/59</b>	
PHYSICIAN'S NAME (Type) <b>L. Maldve, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 12-2-1959</b>		22b. DATE THEREOF <b>12-2-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moses Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brewery Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ann Seese</b>		ADDRESS <b>Annapolis Md</b>	
24a. REC'D BY REGISTRAR <b>DEC 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13102

13115

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>14 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>O.</u> Last <u>Duncan</u>		4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 31, 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A. J. TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>ROSA ANN JUSTICE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CLARENCE C. DUNCAN, Pocomoke City, Md.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lower Nephron Nephrosis</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>13 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterial Embolism to right common femoral Artery</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 Oct</u> , 19 <u>59</u> , to <u>10 Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10 Nov</u> , 19 <u>59</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>707 Camden Ave. Salisbury Md.</u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u>		M.D. <u>  </u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH C. FITZGERALD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-12-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BAPTIST CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Watson</u>		ADDRESS <u>POCOMOKE CITY, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

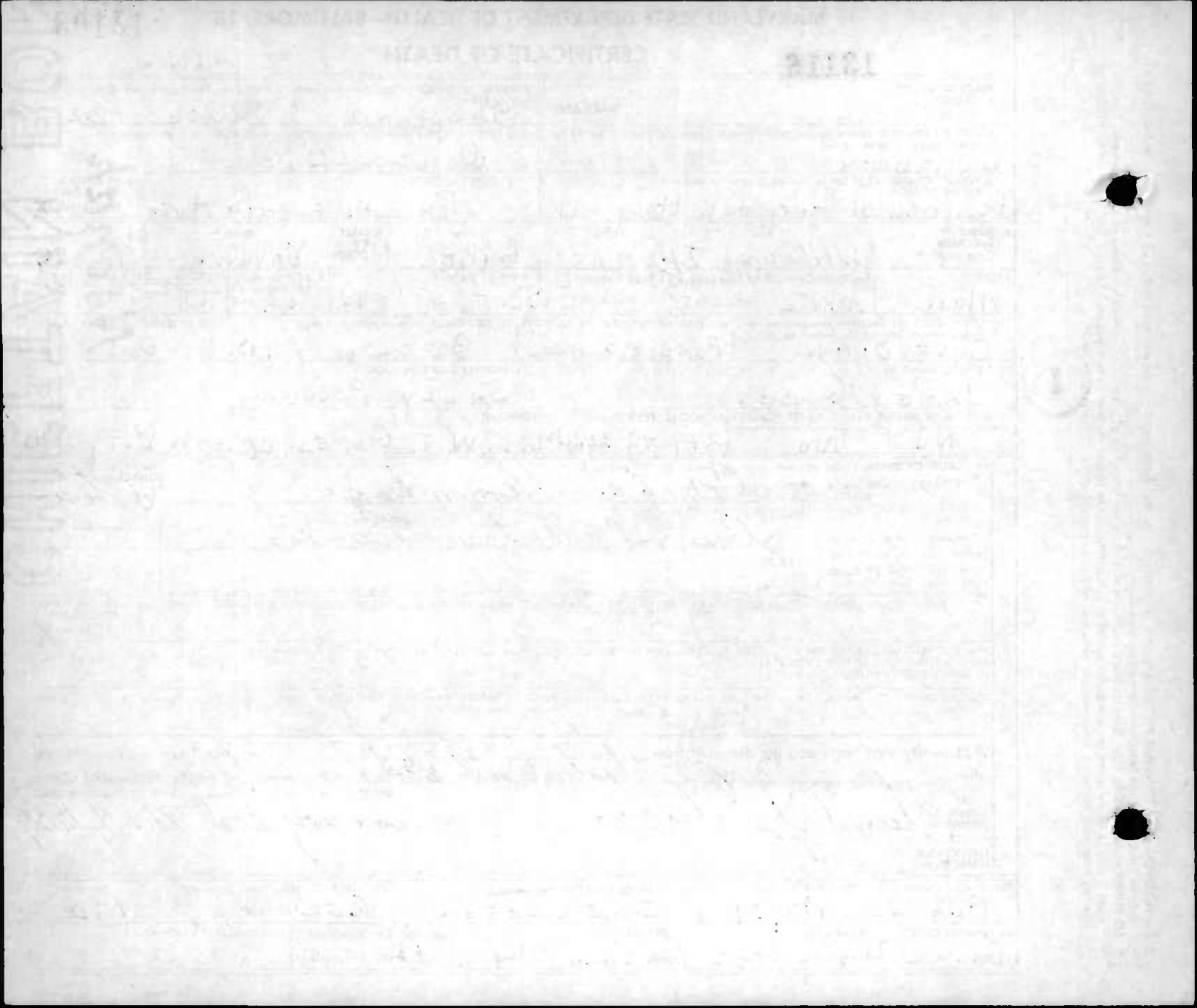
1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

13116

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City 23X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>				d. STREET ADDRESS <u>PHILADELPHIA AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William THOMAS Gibbs</u>				4. DATE OF DEATH Month Day Year <u>November 7 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 5 1890</u>		9. AGE (In years lost birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JAMES GIBBS</u>				14. MOTHER'S MAIDEN NAME <u>SALLY POWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-12-3261</u>		INFORMANT Address <u>MRS. W. T. GIBBS, Ocean City MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Short</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/7</u> , 19 <u>59</u> , to <u>11/7</u> , 19 <u>59</u> that I last saw the deceased alive on <u>11/7</u> , 19 <u>59</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Selmore</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury Md. Nov. 7, 1959</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burbage Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13117

CERTIFICATE OF DEATH

13104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>58 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>224 Glen Ave.,</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>COSTON</b> Last <b>GOSLEE</b>		4. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18. 1776</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Dairyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Milk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Belle Ball</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mrs. J.C. Goslee, Same</b>	
17. INFORMANT <b>Mrs. J.C. Goslee, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, Acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>2-3 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Insufficiency</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/1</b> , 19 <b>59</b> , to <b>11/17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/20</b> , 19 <b>59</b> , and that death occurred at <b>8:40 A.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/17/59</b>	
ACTUAL SIGNATURE <b>Rufus S. Gardner</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. Rufus S. Gardner Pine Buff Rd., Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b> ADDRESS		24a. REC'D BY REGISTRAR <b>NOV 19 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Carling S. K...</b>	

Norman T. Baker





13118

## CERTIFICATE OF DEATH

Reg. Dist. No.

13105

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 Wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Middle Last <u>ROBERT</u> <u>Patterson</u> <u>Graham</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER</u> <u>20</u> <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 17, 1912</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Enginer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert P. Graham Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Caroline R. Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>				16. SOCIAL SECURITY NO. <u>283-05-2932</u>			
17. INFORMANT <u>Mrs. Julia W. Graham, Same</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.9</u> DUE TO <u>Carcinoma a toxis, metastatic from Intestinal Tract</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>September, 1959</u> to <u>Nov. 20, 1959</u> that I last saw the deceased alive on <u>Nov. 20, 1959</u> , and that death occurred at <u>129</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>10/20/59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill, Jr.</u>				Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

Norman F. Baker

4  
Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13112

County of ... State of ...

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13119

## CERTIFICATE OF DEATH

13106

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) o. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shiloh</u> <u>Tinny</u>			
c. LENGTH OF STAY IN 1b <u>9 Days</u>				d. STREET ADDRESS <u>23X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>E.</u> Last <u>Hancock</u>				4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4 - 1878</u>	
9. AGE (In years last birthday) <u>81 1/2</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>22</u> Hours <u>34</u> Min. <u>00</u>		IF UNDER 24 HRS. Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTH PLACE (State or foreign country) <u>Shiloh, md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>md</u>							
13. FATHER'S NAME <u>Thomas Hancock</u>				14. MOTHER'S MAIDEN NAME <u>Mary Truett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-34-3229</u>			
17. INFORMANT <u>Willie J. Hancock</u>				Address <u>Snow Hill, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-18</u> , 19 <u>59</u> , to <u>11-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-26</u> , 19 <u>59</u> , and that death occurred at <u>8:34</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Selburne</u>				DATE SIGNED <u>11/26/59</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>				M.D. <u>Salisbury Md</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Shiloh, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Dennis</u>				24a. REC'D BY REGISTRAR <u>Snow Hill, md</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13107

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Route # 2 Box 57</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Willie Hardman</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>11-6-59</u> <u>19</u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>C</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2-3-1930</u>	
<b>9. AGE</b> (In years last birthday) <u>29</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during past working life, even if retired) <u>LABORER</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Crescent Plant</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Miss.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Link Hardman</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Krene Johnson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>NOT KNOWN</u>				<b>16. SOCIAL SECURITY NO.</b>  		<b>17. INFORMANT</b> <u>Mrs. Lucille Hardman</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> <u>981x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound abdomen</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>13 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Shot in abdomen and chest by John Hayes in quarrel.</u>			
<b>20c. TIME OF INJURY</b> Hour <u>10-24</u> a.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Church Tavern</u>		<b>20f. (City or town) (County) (State)</b> <u>Allen</u> <u>Wicomico</u> <u>Md.</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Earl L. Royer</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>  	
<b>EXAMINER'S (Type)</b> <u>Earl L. Royer, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>11-9-59</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11-11-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. CALVARY CEM.</u>		<b>22d. LOCATION (City, town, or county) (State)</b> <u>Fruitland</u> <u>Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Thornton B. Jolley Salisbury, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>NOV 13 1959</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

- 1 -



13121

## CERTIFICATE OF DEATH

Reg. Dist. No.

13108

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD Lee HEARN</u>				4. DATE OF DEATH Month Day Year <u>November 23 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 17, 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationery &amp; Gift</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Store</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph W. HEARN</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET ELIZABETH Millen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>Mrs E.L. HEARN, SAME.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Serious</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>11/20/59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2, 1957</u> , to <u>Nov 23, 1959</u> that I last saw the deceased alive on <u>11/22/59</u> , 19 <u>59</u> , and that death occurred at <u>12:05 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>AC Mitchell</u>		M.D. <u>Salisbury Md</u>		ADDRESS (Street, city or town, state) <u>211 MARYLAND AVE, SALISBURY MD.</u>		DATE SIGNED <u>11/23/59</u>	
PHYSICIAN'S NAME (Type) <u>ANDREW C. MITCHELL, 211 MARYLAND AVE, SALISBURY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis J. Johnson Co., Salisbury</u>				24a. REC'D BY REGISTRAR <u>Franklin B. Hill Jr.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

11

1912

Blank certificate form with faint lines and text, including fields for name, age, sex, race, occupation, cause of death, and date of death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13122 CERTIFICATE OF DEATH

Reg. Dist. No. 13199

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Holland</b> Last <b>Holland</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>unk</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>1</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. Holland</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of pancreas with metastases</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 20, 19 59</b> to <b>Nov. 1, 19 59</b> , that I last saw the deceased alive on <b>Nov. 1, 19 59</b> , and that death occurred at <b>5:50 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Kosmahly</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M.D.</b>		DATE SIGNED <b>11/1/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-7-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>South Lakes Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Bethesda and</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Booker W. Welch</b>		ADDRESS <b>Salisbury, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	

CERTIFICATE OF DEATH

13133

STATE OF NEW YORK  
COUNTY OF [ ]

I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the [ ] day of [ ] 19[ ] at [ ] in the County of [ ] State of New York, [ ]

aged [ ] years, [ ] of legal age, [ ] of the County of [ ] State of New York, [ ]

did die of [ ] at [ ] in the County of [ ] State of New York, [ ]

the cause of death being [ ]

and that the death was not caused by any of the following diseases, [ ]

namely, [ ]

and that the death was not caused by any of the following diseases, [ ]

namely, [ ]

and that the death was not caused by any of the following diseases, [ ]

namely, [ ]

and that the death was not caused by any of the following diseases, [ ]

namely, [ ]

and that the death was not caused by any of the following diseases, [ ]

namely, [ ]

and that the death was not caused by any of the following diseases, [ ]

namely, [ ]

and that the death was not caused by any of the following diseases, [ ]

namely, [ ]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13110

13150

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Pittsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.#</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>HOLLOWAY</b> Last <b>HOLLOWAY</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>5th</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1887</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>17</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>R.D.# Pittsville, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>LEVIN G. HOLLOWAY</b>		14. MOTHER'S MAIDEN NAME <b>MARY G. WELLS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. A. Mae Holloway (Wife) R.D.# Pittsville Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion</b> DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>5 yrs ?</b> <b>5 yrs ?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 1</b> , 19 <b>50</b> , to <b>11-5-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 5th</b> , 19 <b>59</b> , and that death occurred at <b>7:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Willards, Maryland</b> DATE SIGNED <b>Nov. 5 / 1959</b> ACTUAL SIGNATURE <b>Frank R. Lewis</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Frank R. Lewis</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 7 / 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pittsville Cem (New Part) Pittsville, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF THE

1915

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13111	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>Patrick Ave.</u>						
3. NAME OF DECEASED (Type or print) First <u>Bernice</u> Middle <u>Johnson</u> Last <u>Johnson</u>					4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>59</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 3, 1939</u>		9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>4</u> IF UNDER 24 HRS. Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>Alonzo Jones Johnson</u>					14. MOTHER'S MAIDEN NAME <u>Delsie Jones</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Delsie Markland, East Rd. City</u>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute necrotizing hepatitis</u> <u>580X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Salisbury</u>		(County) <u>Wicomico</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Earl L. Royer</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>11-9-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Macedonia Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Dames Quarter, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley, Salisbury, Md.</u>						ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 13 59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13124  
CERTIFICATE OF DEATH

13112

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>				c. LENGTH OF STAY IN lb <b>14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>---</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Chestnut Harry Jones</b>				4. DATE OF DEATH Month Day Year <b>Nov. 11 19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-5-1874</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Stockton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pirum E. Jones</b>				14. MOTHER'S MAIDEN NAME <b>Elisa M. ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		INFORMANT Address <b>Deer's Head Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (d.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia due to</b> <b>422.1</b> DUE TO <b>Arteriosclerotic Cardiovascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Disease Decompensated</b> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>10 Days</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic Hypertrophy, Benign.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Oct. 28</b> , 19 <b>59</b> , to <b>Nov. 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 11</b> , 19 <b>59</b> , and that death occurred at <b>9:25A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>V. Juerman</b> M.D. <b>Deer's Head State Hospital</b> <b>11-11-59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b> <b>Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-15-59</b>		22c. NAME OF CEMETERY <del>DEER'S HEAD</del> <b>Porterville Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Stockton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Henry Watson</b> <b>Pocomoke City, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

091

2

1

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

1912

Married

Age

Sex

Color

Place of Birth

Education

Occupation

Religion

Marital Status

Parents' Names

Place of Birth of Parents

Marriage License

Witnesses

Signature of Registrar

Signature of Minister

Signature of Witnesses

Date

Signature of Bride

Signature of Groom

Signature of Minister

Signature of Witnesses

Signature of Registrar

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13113

Reg. Dist. No.

13151

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D.# 5 Glen Ave. Ext.</b>				e. STREET ADDRESS <b>R.D.# 5 Glen Ave. Ext</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELLEN</b> Last <b>KELLY</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>17</b> th 19 <b>59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Baby</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 23, 1959</b>	9. AGE (In years last birthday) <b>0</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>24</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Md (Hospital)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Marvin N. Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Mary Lou Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. Marion N. Kelly (Father) R.D.# 5 Glen St Ext. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>763.0</b> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____</p> </div> <div style="width: 25%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 18, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b> (State) _____		
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>NOV 20 1959</b> DATE	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Howard</i>		DATE SIGNED <b>Nov. 18 1959</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2082293XV4

26174



## CERTIFICATE OF DEATH

Reg. Dist. No.

13152

13114

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>H.D.# (Maple Shade Nursing Home)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MATILDA</b> Middle <b>ALICE</b> Last <b>LANKFORD</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>19</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22, 1863</b>
9. AGE (In years last birthday) <b>96</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Isaac Wesley Fleming</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rebecca Pusey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mr. W. Alton Lankford (Son) 900 N. Division St Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Chronic Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>104 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1957</b> , to <b>Nov 18 1959</b> , that I last saw the deceased alive on <b>Nov 18 1959</b> , and that death occurred at <b>9:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Nov. 20 1959</b> DATE SIGNED			
ACTUAL SIGNATURE <b>H.S. Kuhlman</b> M.D.		DATE SIGNED <b>Nov. 20 1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. H.S. Kuhlman</b>		<b>Sharptown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 21, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY -SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>NOV 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15112

CERTIFICATE OF DEATH

15112

Location: Baltimore  
Residence: Baltimore  
Age: 30

Death occurred on 11/11/1932 at 10:30 AM.  
Cause of death: ...

Declassified by ...  
Date of declassification: ...

Declassification authority: ...  
Declassification code: ...

Declassification code: ...  
Declassification code: ...

Declassification code: ...  
Declassification code: ...

Declassification code: ...  
Declassification code: ...

Declassification code: ...  
Declassification code: ...

Declassification code: ...  
Declassification code: ...

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7 E. Elizabeth Street</b>		d. STREET ADDRESS <b>7 E. Elizabeth Street</b>	
3. NAME OF DECEASED (Type or print) <b>Ida Mae LeCates</b>		4. DATE OF DEATH <b>Nov. 30 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Delmar, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Nichols</b>		14. MOTHER'S MAIDEN NAME <b>Theodosia Maddox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Lottie Wainwright, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Hypertension + Diabetes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension + Diabetes</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/30</b> , 19 <b>52</b> , to <b>death</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/30</b> , 19 <b>59</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ernest M. Larmore</b>		ADDRESS (Street, city or town, state) <b>100 Grove St. Delmar, Del.</b>	
PHYSICIAN'S NAME (Type) <b>Ernest M. Larmore</b>		DATE SIGNED <b>11/30/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-2-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Marvel Co - Delmar, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 3 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~burial~~ papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 C, Film G252 11/19/59 iwk

13116

13125

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> <b>46x-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>24 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Susie</b> Middle <b>Jefferson</b> Last <b>Marsh</b>		4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/3/1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. UNDER 1 YEAR Months <b>74</b> Days <b>12</b> Hours <b>19</b> Min.	11. UNDER 24 HRS. Months <b>74</b> Days <b>12</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Schoolteacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Schoolteacher</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Spriggs</b>		14. MOTHER'S MAIDEN NAME <b>Emily Lankford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic congestion of the lungs</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 12, 1959</b> to <b>November 12, 1959</b> , that I last saw the deceased alive on <b>November 12, 1959</b> , and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. V. Maldve</b>		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>11/13/59</b>	
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/14/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>DELMAR DELAWARE</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas H. Walker</b>		24a. REC'D BY REGISTRAR <b>NOV 16 '59</b>	
ADDRESS <b>Salisbury, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>	

THE NATIONAL ACADEMY OF SCIENCES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13126

13117

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stocketon</i>	
c. LENGTH OF STAY IN 1b <i>4 days</i>		23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pennsylvania General Hosp.</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Frederick</i> Middle <i>J.</i> Last <i>Mason</i>		4. DATE OF DEATH Month <i>November</i> Day <i>26</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>May 19-1917</i>
9. AGE (In years last birthday) <i>42/6/17</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lumber Mill</i>	
11. BIRTHPLACE (State or foreign country) <i>Stocketon, md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Samuel Mason</i>		14. MOTHER'S MAIDEN NAME <i>Louise Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>210-16-2658</i>	
17. INFORMANT <i>Mary Staley</i>		Address <i>406 Market St. Snow Hill</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chemia</i> <i>446X</i> DUE TO (b) <i>Nephrosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <i>Hypertensive encephalopathy; Art. Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/24</i> , 1959, to <i>11/26</i> , 1959, that I last saw the deceased alive on <i>Nov. 26</i> , 1959, and that death occurred at <i>5:08 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>David J. Gilmore</i>		ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>Nov. 27, 1959</i>	
PHYSICIAN'S NAME (Type)			
22a. DATE OF REMOVAL (Specify) <i>Nov 30 1959</i>		22b. NAME OF CEMETERY OR CREMATOR <i>Stocketon</i>	
22c. LOCATION (City, town, or county) <i>md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne E. Summa</i>		24a. REC'D BY REGISTRAR <i>Nov 30 '59</i>	
ADDRESS <i>Snow Hill, md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G253 12/3/59 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No.

13118

13127

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>India</u> Middle <u>Matthews</u> Last <u>Matthews</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1882</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>	IF UNDER 24 HRS. Min. <u>77</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Cropper</u>				14. MOTHER'S MAIDEN NAME <u>Jannie Cropper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Lillian Jones 408 Lake St. Salis Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Tuberculosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Carman Tuberculosis</u> DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 13, 1959</u> to <u>Nov 20, 1959</u> , that I last saw the deceased alive on <u>Nov 20, 1959</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Carrie Hearsh</u> M.D.				ADDRESS (Street, city or town, state) <u>226 N. Division St. Salisbury Md.</u>			
PHYSICIAN'S NAME (Type) <u>Carrie Hearsh</u>				DATE <u>Nov 30 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/ 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton Stewart</u>				ADDRESS <u>Salis. Md</u>		24a. REC'D BY REGISTRAR <u>NOV 30 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1911

1911

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13128

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Del</u> b. COUNTY <u>Sussex</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAGSBORO 46X-3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>WILSON</u> Middle <u>O.</u> Last <u>McCabe</u>			4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1901</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR: Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POULTRYMAN &amp; FEED DEALER.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>OLLIE MCCABE</u>			14. MOTHER'S MAIDEN NAME <u>VIRGINIA GRAY</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>221-18-8113</u> INFORMANT <u>Mrs. OLA MCCABE</u> Address <u>DAGSBORO, Del.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Ventricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Ht dis.</u> (c) <u>?</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u> <u>6 hours</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>16 November 1959</u> , to <u>16 Nov.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>16 Nov</u> , 19 <u>59</u> , and that death occurred at <u>6:25 P.</u> M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u>			ADDRESS (Street, city or town, state) <u>11-16-59</u>		
PHYSICIAN'S NAME (Type) <u>Watson &amp; Gray Frankford, Del.</u>			DATE <u>NOV 19 '59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-19-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>RED MEN'S Cem.</u>	22d. LOCATION (City, town, or county) <u>DAGSBORO</u>	(State) <u>Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson &amp; Gray Frankford, Del.</u>			24a. REC'D BY REGISTRAR <u>Arthur S. Hana</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1313

DEPARTMENT OF HEALTH

1313

RECEIVED  
JAN 11 1913  
U.S. DEPT. OF HEALTH  
BUREAU OF VITAL STATISTICS

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Name", "Age", "Sex", "Race", "Occupation", "Cause of Death" are faintly visible.]*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13120

13154

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>South Division St Ext</b>		d. STREET ADDRESS <b>South Division St Ext</b>	
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>PUSEY</b> Last <b>MC DANIEL</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>27th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>7</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Eden. Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Albert M. Bozman</b>	
14. MOTHER'S MAIDEN NAME <b>Matilda Caroline Pusey</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		17. ADDRESS <b>Miss Myrtle U. McDaniel (Daughter) Fruitland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO <b></b> (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>July</b> , 19 <b>59</b> , to <b>Nov. 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>October 29</b> , 19 <b>59</b> , and that death occurred at <b>3:00 A.M.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Thomas C. Hill</b> M.D.		DATE SIGNED <b>Nov. 28 / 1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Thomas C. Hill</b>		ADDRESS <b>Pine Bluff Road Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 29, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Church Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Fruitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>DATE DEC 2 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

Location

Residence

Local Division

Age

Sex

Color

Marital Status

Occupation

Cause of Death

Place of Death

Time of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Witness

Signature of Burial Officer

Signature of Undertaker

Signature of Minister

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13129

13121

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>INISULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>TAMMY SUE McINTYRE</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 10 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/8/1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>HARVEY McIntyre</u>		14. MOTHER'S MAIDEN NAME <u>Betty Jane Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr. HARVEY McIntyre</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.6</u> DUE TO <u>Congenital Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coarctation of the Aorta</u> (c) <u>Ventricular Septal Defect</u> <u>(Aorta actually ended blindly)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>approx 48 hrs from birth</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/8</u> , 1959, to <u>11/10</u> , 1959, that I last saw the deceased alive on <u>11/10/59</u> , 1959, and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Agnes C. Kolls</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>11/11/59</u>	
PHYSICIAN'S NAME (Type) <u>ALFRED C. Kolls</u>		<u>Salisbury Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/11/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wic. Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kell + Johnson Co</u> ADDRESS <u>Salisbury Md</u>		24a. REC'D BY REGISTRAR <u>NOV 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>

208217th Abant. Baker

1911

DEPARTMENT OF HEALTH

1313



13130

## CERTIFICATE OF DEATH

13122

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>2 Mons.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Tony Tank Manor</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>BERNICE COOPER MESSICK</b>				4. DATE OF DEATH <b>11 23 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 19, 1877</b>	9. AGE (In years last birthday) <b>81</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		11. BIRTHPLACE (State or foreign country) <b>M. ryland</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Wm. H. H. Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Isabell Harcum</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs James A. Phillips, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-23</b> , 19 <b>56</b> , to <b>11-23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11-23</b> , 19 <b>59</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. A. Briele</b>				ADDRESS (Street, city or town, state) <b>Medical Center Salisbury, Md.</b>			
PHYSICIAN'S NAME (Type) <b>H. A. Briele</b>				DATE SIGNED <b>11-24-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Phillips Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Quantico, M. ryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR <b>DEC 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**1** **24 hours** after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed by the attending physician or hospital. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this filing has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## CERTIFICATE OF DEATH

13131

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 4/17/59</u>		STREET ADDRESS <u>1</u>		(If rural give location) <u>South Division</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>							
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Larry</u>		(Middle) <u>B.</u>		(Last) <u>Morris</u>		(Month) <u>Nov.</u> (Day) <u>8th</u> (Year) <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>24 Dec 1871</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-Mason</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leonard Morris</u>				14. MOTHER'S MAIDEN NAME <u>Sallie <del>Ann</del> Richardson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-8390</u>		17. INFORMANT & ADDRESS <u>Mr. John H. Parsons-Record St Sal. Records of Pine Bluff State Hospital Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Infarction (suspect)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Semilethal</u>							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>8 Nov</u>, 19<u>59</u>, to <u>8 Nov</u>, 19<u>59</u>, that I last saw the deceased alive on <u>8 Nov</u>, 19<u>59</u>, and that death occurred at <u>8:50 P</u>.M, from the causes and on the date stated above.</b>							
SIGNATURE <u>Joseph C. Fitzgerald</u>		M.D. <u>707 Camden Ave Salisbury Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>8 Nov 59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 11, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Pittsville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pittsville, Maryland</u>	
24. REC'D BY REGISTRAR <u>NOV 12 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Moore</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway &amp; Company-Salisbury, Md.</u>			



## CERTIFICATE OF DEATH

Reg. Dist. No.

13124

13132

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WOCCOSTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>23X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEN GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>WILLIAMS ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH NANCY NOTTINGHAM</u>				4. DATE OF DEATH Month Day Year <u>NOV 11 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 30 1907</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RUBY DAVIS</u>				14. MOTHER'S MAIDEN NAME <u>BOSSIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>224-28-8059</u>		17. INFORMANT Address <u>Mrs. JOHNNIE WILLIS BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>460X</u> DUE TO <u>PHLEBITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Varicose Veins</u> (c) <u>Varicose Veins</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-4</u> , 19 <u>59</u> , to <u>11-11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-11-59</u> , 19 <u>59</u> , and that death occurred at <u>130P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford E. Schott</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT M.D. BERLIN MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOWEN</u>		22d. LOCATION (City, town, or county) (State) <u>NEWARK MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13125

13133

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> d. STREET ADDRESS <u>2342-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Peter</u> First <u>Outter</u> Middle <u>Outten</u> Last			<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>21</u> Year <u>1959</u>				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>E</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 23, 1901</u>	<b>9. AGE</b> (In years last birthday) <u>58</u> yrs.	<b>10. UNDER 1 YEAR</b> Months <u>5</u> Days <u>18</u> Hours <u>15</u> Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Seaman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>City trash burner</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			<b>13. FATHER'S NAME</b> <u>John Outten</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Smith</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				
<b>16. SOCIAL SECURITY NO.</b> <u>213-05-8438</u>			<b>17. INFORMANT</b> <u>Martha Outten - Pocomoke, md.</u> Address				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>916.8</u> DUE TO (b) <u>Strangulated left inguinal hernia</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>4 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2nd &amp; 3rd Burns 36% Body Surface</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Set fire to clothes burning trash city dump</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>11/11/59</u> Hour <u>11:45</u> a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>	<b>20d. INJURY OCCURRED</b> While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>City Dump</u>	<b>20f. (City or town)</b> <u>Pocomoke</u>	<b>(County)</b> <u>Worcester</u>	<b>(State)</b> <u>md</u>		
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <u>Earl L. Royer</u>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <u>Earl L. Royer</u>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>DATE SIGNED</b> <u>11-24-59</u>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11-29-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodtown</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Pocomoke, md.</u>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edgar Wharton - New Church, Va.</u>			<b>ADDRESS</b>				
<b>24a. REC'D BY REGISTRAR</b> <u>DEC 2 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Harris</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







## CERTIFICATE OF DEATH

Reg. Dist. No.

13126

13155

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsburg</b>			c. LENGTH OF STAY IN 1b <b>10 Yrs.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt # 2</b>			/ d. STREET ADDRESS <b>Rt # 2</b>		
3. NAME OF DECEASED (Type or print) <b>VIRGIL</b> <b>GEORGE</b> <b>PARSONS</b>			4. DATE OF DEATH Month <b>11</b> Day <b>23</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1887</b>	9. AGE (In years lost birthday) yrs. <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Benjamin Parsons</b>			14. MOTHER'S MAIDEN NAME <b>Martha West</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-14-8349</b>		17. INFORMANT <b>Mrs. Rhoda M. Parsons Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary occlusion</b> DUE TO (c) <b>coronary arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 days</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic heart disease with decompensation</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>Nov 24, 1959</b> to <b>Nov 23, 1959</b> , that I last saw the deceased alive on <b>Nov 24, 1959</b> , and that death occurred at <b>12:15 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>L.V. Sohler</b> M.D. <b>Delmar, Maryland</b>			DATE SIGNED <b>11-24-59</b>		
PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler 303 East St., Delmar, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-25-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Farlow's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pittsville, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>			24a. REC'D BY REGISTRAR DATE <b>NOV 30 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Norman + Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MD		DATE OF DEATH 1911-11-11	
NAME OF DECEASED JAMES H. HARRISON		SEX Male	
AGE 45		RACE White	
PLACE OF BIRTH Baltimore, Md		OCCUPATION Clerk	
MARITAL STATUS Married		CAUSE OF DEATH Heart Disease	
PLACE OF DEATH Baltimore, Md		TIME OF DEATH 10:00 AM	
SIGNATURE OF PHYSICIAN J. H. Harrison		SIGNATURE OF REGISTRAR J. H. Harrison	
SIGNATURE OF WITNESS J. H. Harrison		SIGNATURE OF WITNESS J. H. Harrison	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

1

13156

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13127

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> <u>Worce</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>		c. LENGTH OF STAY IN 1b <u>minutes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route # 50</u>		d. STREET ADDRESS <u>Route # 3</u>	
3. NAME OF DECEASED (Type or print) First <u>Fletcher</u> Middle <u>E.</u> Last <u>Purnell</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERBERT Purnell</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE BRIDGELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-601-9650</u>	
17. INFORMANT <u>L.T. Purnell, Berlin, Md.</u>		Address <u>Rt # 3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO (b) <u>Hypertensive Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>7 mos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>11-24-59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-24-1956</u> to <u>11-24-1959</u> , that I last saw the deceased alive on <u>11-24-1959</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ivory U. Sully Jr. M.D.</u>		ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>11-26-59</u>	
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully Jr M.D.</u>		<u>Berlin, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u>		ADDRESS <u>Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



13128  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Salisbury (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 3 (Delmar Rd)</b>		d. STREET ADDRESS <b>R.D.# 3 (Delmar Rd)</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN FREDRICK RATCLIFFE</b>		4. DATE OF DEATH Month Day Year <b>NOV. 10th 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <u>MARRIED</u> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1, 1894</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>	11. BIRTHPLACE (State or foreign country) <b>Knoxville, Tenn.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Charles Fredrick Ratcliffe</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Mae Jett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W.# 1</b>	
17. INFORMANT <b>Mrs. Lula M. Ratcliffe (Wife)</b>		Address <b>R.D.# 3 (Delmar Rd) Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , 19____, to <b>1959</b> , 19____, that I last saw the deceased alive on <b>10/15/59</b> , 19____, and that death occurred at <b>11:30 P.M.</b> of the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>220 N. Division St. Salisbury, Maryland</b> DATE SIGNED <b>Nov. 11 / 1959</b> ACTUAL SIGNATURE <b>Carrie I. Hearne</b> M.D. <b>PI-9-4773</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Carrie I. Hearne</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 13, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24a. REC'D BY REGISTRAR <b>NOV 16 '59</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>	

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)  
15M 9/58

— 4 —

Figure 1. The effect of the concentration of the *Agrobacterium* suspension on the transformation efficiency of *Agrobacterium* strains.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
c. LENGTH OF STAY IN TB <b>10 Yrs.</b>		d. STREET ADDRESS <b>107 Livingstone St.,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>107 Livingstone St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JEANNETTE WHITE</b> Middle <b>RICHARDSON</b> Last		4. DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1870</b>
9. AGE (In years lost birthday) <b>89</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Capt. T.W.H. White</b>		14. MOTHER'S MAIDEN NAME <b>Louisa A. Fooks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Elmore E. Richardson Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Passive Congestive pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac Failure</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-1, 1959</b> , to <b>11/15, 1959</b> , that I last saw the deceased alive on <b>11/15, 1959</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/16/59</b>			
ACTUAL SIGNATURE <b>Wm B Smith</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. William B. Smith Medical Center Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/18/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Allen Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Allen Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b> ADDRESS		24a. REC'D BY REGISTRAR <b>NOV 17 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1898		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. CAUSE OF DEATH Heart Disease		8. DATE OF DEATH 1943		9. PLACE OF DEATH Home		10. SIGNATURE OF DECEASED (None)	
11. NAME OF NEXT OF KIN Mrs. James H. Harris		12. ADDRESS 1234 Main St. Baltimore, Md.		13. CITY Baltimore		14. STATE Md.		15. COUNTY Baltimore	
16. NAME OF PHYSICIAN Dr. John A. Smith		17. NAME OF FUNERAL HOME None		18. NAME OF BURIAL PLACE None		19. NAME OF CEMETERY None		20. NAME OF INTERMENT None	
21. NAME OF REGISTRAR John A. Smith		22. NAME OF CLERK John A. Smith		23. NAME OF ASSISTANT CLERK John A. Smith		24. NAME OF DEPUTY REGISTRAR John A. Smith		25. NAME OF DEPUTY CLERK John A. Smith	

13135

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		e. STREET ADDRESS <b>729 Roger St</b>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>FRANKLIN</b> Last <b>RIDER</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 17, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Month <b>11</b> Days <b>1</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner &amp; Operator-Ice Cream Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>(Retired)</b>	
11. BIRTHPLACE (State or foreign country) <b>Wicomico County Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James Rider</b>		14. MOTHER'S MAIDEN NAME <b>Katie Fetzler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>220-12-1593</b>	
17. INFORMANT <b>Mrs. Lorena Campbell (Daughter)</b>		Address <b>729 Roger St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Acute Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/23/53</b> , 19___, to <b>11/18/59</b> , 19___, that I last saw the deceased alive on <b>11/17/59</b> , 19___, and that death occurred at <b>12:50</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Nov. 19 1959</b> DATE SIGNED ACTUAL SIGNATURE <b>Dr. Andrew C. Mitchell</b> M.D. <b>Nov. 19 1959</b> PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b> <b>Maryland Ave. Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 20, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY -SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

15182

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

PROFESSION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

PROFESSION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

PROFESSION

DATE OF MARRIAGE

NAME OF SPOUSE

## CERTIFICATE OF DEATH

Reg. Dist. No.

13136

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>Girl</u> Last <u>Simpkins</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-23-59</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INFANT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm. Edward Simpkins</u>		14. MOTHER'S MAIDEN NAME <u>MARIE PARSONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>Mr. Wm. E. Simpkins, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.5 asphyxia</u> DUE TO (b) <u>Immaturity (23 wks fetus)</u> DUE TO (c) <u>Premature Rupt. Membranes</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/23</u> , 19 <u>59</u> , to <u>11/23</u> , 19 <u>59</u> that I last saw the deceased alive on <u>11/23</u> , 19 <u>59</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Christensen</u> M.D. <u>PEN. MED. BLDG.</u>				DATE SIGNED <u>11-25-59</u>			
PHYSICIAN'S NAME (Type) <u>Osborn Christensen Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hill + Johnson Co Salisbury, MD</u> <u>Norman T. Baker 2082 261XDU</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1915

1915

1. Name of deceased  
2. Sex  
3. Age  
4. Date of death  
5. Place of death  
6. Cause of death  
7. Signature of physician  
8. Signature of registrar  
9. Date of registration



1  
4  
M  
X  
1

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13158

## CERTIFICATE OF DEATH

Reg. Dist. No.

13132

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b> c. LENGTH OF STAY IN 1b <b>(Rural) Salisbury</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1 Shad Point</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Salisbury (Rural)</b> d. STREET ADDRESS <b>R.D.# 1 Shad Point</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>CARL</b> Middle <b>MANSFIELD</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>17th</b> Year <b>19 59</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1880</b>	9. AGE (In years last birthday) yrs. <b>79</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ship Carpenter-Retired-Boat</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shad Point (Wico.Co.) Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>William W. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Theodosia A. Disharoon</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Theodosia Pruitt (Daughter) R.D.#1 Shad Point Salisbury, Maryland</b>		17. ADDRESS (Street, city or town, state) <b>Nov. 18 1959</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Acute Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c) <b>years</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hours</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4-29</b> , 19 <b>58</b> , to <b>17 Nov</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>16 Nov</b> , 19 <b>59</b> , and that death occurred at <b>5:00A</b> , from the causes and on the date stated above. DATE SIGNED <b>Nov. 18 1959</b> ADDRESS (Street, city or town, state) <b>407 Camden Ave. Salisbury, Maryland</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 19, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cemetery-R.D.# Salisbury, Maryland</b>		22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraw...</b>		

1913

CENTRAL BANK OF NEW YORK

1913

Alfred

Jan 1913



Alfred

(Jan 1)

Alfred

U.S. 1000

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U.S. 1000

U.S. 1000

1000



Nov. 1913

Nov. 1913

Nov. 1913

Nov. 1913

Nov. 1913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 14 & 22 Film G253 12/3/59 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

13133

13137

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Md.</b> c. LENGTH OF STAY IN lb <b>7 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R. D. #2, Cambridge</b> d. STREET ADDRESS <b>--</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Willey Stanton</b>			4. DATE OF DEATH Month Day Year <b>11 24 1959</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-21-89</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>09x-2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge, M d.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Wm. Edward Willey</b>		
14. MOTHER'S MAIDEN NAME <b>Sally Smith</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		
16. SOCIAL SECURITY NO. <b>INFORMANT</b>			17. DEATH RECORDS <b>Deer's Head Hospital</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic congestion of the lungs</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c), stating the underlying cause (c). (b) <b>Hypertensive arteriosclerotic cardiovascular disease</b> (c) <b>disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Deer's Head State Hospital</b>	
20f. (City or town) <b>Salisbury</b>		20g. (County) <b>Dorchester</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>11-17</b> , 19 <b>59</b> , to <b>11-24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11-24</b> , 19 <b>59</b> , and that death occurred at <b>3:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>Nov 30 1959</b>					
22. ACTUAL SIGNATURE <b>L. V. Maldve, M. D.</b> M.D. <b>Salisbury Maryland</b>					
23. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 26, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Pk.</b>	
22d. LOCATION (City, town, or county) <b>Cambridge, Maryland</b>		22e. (State) <b>Maryland</b>		22f. (Country) <b>U. S. A.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service, Cambridge, Md.</b>		23a. ADDRESS <b>Cambridge, Md.</b>		23b. DATE <b>NOV 30 1959</b>	
23c. REGISTRAR'S SIGNATURE <b>Carroll S. Thomas</b>		23d. (City, town, or county) <b>Salisbury</b>		23e. (State) <b>Maryland</b>	

# CERTIFICATE OF DEATH

1913



1913

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Occupation: \_\_\_\_\_

7. Usual abode: \_\_\_\_\_

8. Date of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Cause of death: \_\_\_\_\_

11. Signature of physician: \_\_\_\_\_

12. Signature of registrar: \_\_\_\_\_

13. Signature of informant: \_\_\_\_\_

14. Signature of witness: \_\_\_\_\_

15. Signature of registrar: \_\_\_\_\_

16. Signature of informant: \_\_\_\_\_

17. Signature of witness: \_\_\_\_\_

13138

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>24 Hrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u> d. STREET ADDRESS <u>1 Quantico Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kedrick</u> Middle <u>STILTNER</u> Last <u>STILTNER</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 1, 1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAR PARTS</u>	9. AGE (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Salie Stiltner</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>224-03-3113</u> INFORMANT <u>Mrs. Margorie H. Stiltner</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>502.0 Con Pulmonale</u> DUE TO (b) <u>Pulmonary Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Chronic Bronchitis</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>NOV-10</u> , 19 <u>59</u> , to <u>NOV 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>3:18 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>Nov 11, 1959</u>	
PHYSICIAN'S NAME (Type) <u>DAVID J. Gilmore</u>		<u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-14-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Clinch Valley Mem. Cem. Rich Lands, VA</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury</u> ADDRESS <u>Norman F. Baker</u>		24a. REC'D BY REGISTRAR <u>NOV 13 '59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Frank</u>

1313

OFFICE OF THE SECRETARY OF THE ARMY

DEPARTMENT OF THE ARMY

1313

TO THE SECRETARY OF THE ARMY  
FROM THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or official communication.]



## CERTIFICATE OF DEATH

Reg. Dist. No.

13139

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>251 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 3, Salisbury, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>---</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Garrison</u> Last <u>Truitt</u>				4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23/1867</u>		9. AGE (In years lost birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown George Truitt</u>				14. MOTHER'S MAIDEN NAME <u>Short Clarice Donaway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown NY</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>Deer's Head Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic congestion of lungs</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>  </u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-24</u> , 19 <u>59</u> , to <u>11-30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-30</u> , 19 <u>59</u> , and that death occurred at <u>5:10 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>				DATE SIGNED <u>11-30-59</u>	
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-2-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Powder Mill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Powellville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson</u>				ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

13132

11

Form with multiple lines for text entry, including fields for name, date, and other vital statistics data.

## CERTIFICATE OF DEATH

Reg. Dist. No.

13140

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>19x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Vanorio Sr.</u>				4. DATE OF DEATH Month Day Year <u>November 10 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 7 1876</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Naples Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew Vanorio</u>				14. MOTHER'S MAIDEN NAME <u>Antionette ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Theodore Vanorio</u>		INFORMANT Address <u>Princess Anne</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Emphysema</u> DUE TO <u>arteriosclerosis</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>P.R. intestinal obstruction</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 11, 1959</u> to <u>November 15, 1959</u> , that I last saw the deceased alive on <u>November 15, 1959</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. H. Briele</u>		M.D. <u>Medical Center</u>		DATE SIGNED <u>11-15-59</u>			
PHYSICIAN'S NAME (Type) <u>H. H. Briele</u>		<u>Salisbury, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Linman</u> ADDRESS <u>Princess Anne Md</u>				24a. REC'D BY REGISTRAR <u>Nov 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. King</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13141

## CERTIFICATE OF DEATH

Reg. Dist. No.

13137

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Salisbury Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>				c. LENGTH OF STAY IN 1b <b>57 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>727 Dennis Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Vaughn</b> Last <b>Vaughn</b>		4. DATE OF DEATH Month <b>11</b> Day <b>10</b> Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1886</b>	9. AGE (In years last birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>225-69-5717</b>		INFORMANT <b>Deer's Head Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332x</b> IMMEDIATE CAUSE (a) <b>Recurrent cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Arteriosclerosis General</b> DUE TO (c) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-14-</b> , <b>1959</b> , to <b>11-10</b> , <b>1959</b> , that I last saw the deceased alive on <b>11-10</b> , <b>1959</b> , and that death occurred at <b>3:05 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>V. Juerman</b>		M.D. <b>Deer's Head State Hospital</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>		DATE SIGNED <b>11/10/59</b>	
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooke M. West</b>				ADDRESS <b>PO Box 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

CERTIFICATE OF DEATH

13141

W

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Date of birth: [illegible]

4. Place of birth: [illegible]

5. Date of death: [illegible]

6. Cause of death: [illegible]

7. Signature of physician: [illegible]

8. Signature of registrar: [illegible]

9. Signature of informant: [illegible]

10. Date of registration: [illegible]

11. Place of registration: [illegible]

12. Signature of registrar: [illegible]

13. Signature of informant: [illegible]

14. Date of registration: [illegible]

15. Place of registration: [illegible]

16. Signature of registrar: [illegible]

17. Signature of informant: [illegible]

18. Date of registration: [illegible]

19. Place of registration: [illegible]

20. Signature of registrar: [illegible]

21. Signature of informant: [illegible]

22. Date of registration: [illegible]

23. Place of registration: [illegible]

Handwritten signature or mark.



13159

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharptown</b>				c. LENGTH OF STAY IN 1b <b>70 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Water Street</b>				d. STREET ADDRESS <b>Water Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Charlie</b> Middle <b>Conley</b> Last <b>Walker</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>24,</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 13, 1888</b>	9. AGE (In years less birthday) yrs. <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wood Baskets</b>		11. BIRTHPLACE (State or foreign country) <b>Sharptown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Walker</b>				14. MOTHER'S MAIDEN NAME <b>Mary Conley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-03-4714</b>		17. INFORMANT <b>Mary Walker, Sharptown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma - Liver &amp; Pancreas</b> <b>157x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Oct 1</b> , 19 <b>59</b> , to <b>Nov 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov 23</b> , 19 <b>59</b> , and that death occurred at <b>1045 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. S. Kuhlman</b>			ADDRESS (Street, city or town, state) <b>Sharptown, Md.</b>		DATE SIGNED <b>11/25/59</b>		
PHYSICIAN'S NAME (Type) <b>H. S. Kuhlman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-27-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Firemans</b>		22d. LOCATION (City, town, or county) (State) <b>Sharptown, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles W. Mansel - Sharptown, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>DEC 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and complete pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G243 12/3/59 iwk

13142

## CERTIFICATE OF DEATH

Reg. Dist. No.

13139

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hosp.</u>		d. STREET ADDRESS <u>RFD #1, Sharptown, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Walker</u> Last <u>Walker</u>		4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1944</u>
9. AGE (In years last birthday) <u>15</u> yrs.		10. IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levin Walker</u>		14. MOTHER'S MAIDEN NAME <u>Rodella Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>340.3</u> DUE TO <u>acute Purulent Meningitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 days</u> (c) <u>4 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hazle Brown - Sharptown Md.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/18</u> , 19 <u>59</u> , to <u>11/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/20</u> , 19 <u>59</u> , and that death occurred at <u>5:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd. 11/21/59</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		SALISBURY, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/26/ 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Sharptown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u> ADDRESS <u>Salisbury Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Clara S. Harris</u>			

13103

UNITED STATES OF AMERICA

13103

*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13140

13143

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Pen.Gen. Hospital</b>				d. STREET ADDRESS <b>Quantico Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>HILLMAN</b> Middle <b>BOWMAN</b> Last <b>WATSON</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>29th</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1904</b>		9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor &amp; Builder-House Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>Daniel Edward Watson</b>				14. MOTHER'S MAIDEN NAME <b>Flora J. Furbush</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Leroy Smith (Sister)</b> Address <b>Salisbury, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Philip A. Insley</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Dr. Philip A. Insley</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 3, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>DEC 2 '59</b>		
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13141

13144 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u> ✓	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 11/17/59</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crisfield</u>		<u>1939.2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Louis</u> (First) <u>Augusta</u> (Middle) <u>Weed</u> (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov.</u> <u>21</u> <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>May 31, 1886</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Elsworth, Me.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Haskel Weed</u>				14. MOTHER'S MAIDEN NAME <u>Syble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT & ADDRESS <u>Records of Pine Bluff State Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Nov. 17</u> , 19 <u>59</u> , <b>to</b> <u>Nov. 21</u> , 19 <u>59</u> , <b>that I last saw the deceased alive on</b> <u>Nov. 20</u> , 19 <u>59</u> , <b>and that death occurred at</b> <u>1:03a</u> M. <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Edward P. Ritchings</u> M.D. <b>ADDRESS</b> (Street, city, town, state) <u>Salisbury, Md.</u> <b>DATE SIGNED</b> <u>11/21/59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/23/59</u>		NAME OF CEMETERY OR CREMATORY <u>Sunnyridge</u>		LOCATION (City, town, or county) (State) <u>Crisfield Md.</u>	
24. REC'D BY REGISTRAR <u>Nov 30 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James Heinman</u>		ADDRESS <u>Crisfield Md</u>	
<u>Thomas Pasquith</u>							



## CÉRTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maple Shade Nursing Home</b>		d. STREET ADDRESS <b>107 New York Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>JUANITA</b> Middle <b>GRACE</b> Last <b>WEIL</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>26th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Manchester Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Edward Oursler</b>	
14. MOTHER'S MAIDEN NAME <b>Julian Weaver</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		17. ADDRESS <b>Mrs. Julia R. Wilson (Daughter) 107 New York Ave. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/26</b> , 19 <b>59</b> , to <b>11/26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/26</b> , 19 <b>59</b> , and that death occurred at <b>12:01 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Laurel, Delaware</b> DATE SIGNED <b>Nov. 27 / 1959</b> ACTUAL SIGNATURE <b>Joseph A. Elliott</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Joseph A. Elliott</b> <b>714 West St. Laurel, Delaware</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 28, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	24a. REC'D BY REGISTRAR <b>NOV 30 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Critch S. Kraus</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13143

## 13145 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Caroline</u> ✓			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>Since 1/13/58</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Federalsburg</u>		<u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>Houston Branch Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Harvey Franklin Wheatley</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov 15 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>1876</u> <u>15 June 1876</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		9. AGE last birthday <u>83</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Reliance, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Edward Wheatley</u>				14. MOTHER'S MAIDEN NAME <u>Drucella Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Records of Pine Bluff State Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
422.1 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C.V. Disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary Tbc. Inactive</u>							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7 Nov.</u> , 19 <u>58</u> , to <u>15 Nov.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 Nov.</u> , 19 <u>58</u> , and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Joseph C. Fitzgerald</u>				ADDRESS (Street, city, town, state) <u>707 Camden Ave. Salisbury</u>		DATE SIGNED <u>10/15/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Nov. 17, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>COKESBURY CEMETERY</u>		LOCATION (City, town, or county) (State) <u>NEAR FEDERALSBURG, MD.</u>	
24. REC'D BY REGISTRAR DATE <u>NOV 19 1959</u>		REGISTRAR'S SIGNATURE <u>C. Elmer L. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton &amp; Son, Federalsburg, Md.</u>			



# MARIANO STATE DEPARTMENT OF HEALTH - BALTIMORE 19

## CERTIFICATE OF DEATH

1. NAME OF DECEASED _____		2. PLACE OF DEATH _____	
3. SEX _____		4. AGE _____	
5. OCCUPATION _____		6. DATE OF DEATH _____	
7. TIME OF DEATH _____		8. PLACE OF BIRTH _____	
9. MARITAL STATUS _____		10. CAUSE OF DEATH _____	
11. MEDICAL HISTORY _____		12. SIGNATURE OF PHYSICIAN _____	
13. SIGNATURE OF DECEASED _____		14. SIGNATURE OF WITNESS _____	
15. ADDRESS OF DECEASED _____		16. ADDRESS OF PHYSICIAN _____	
17. ADDRESS OF WITNESS _____		18. ADDRESS OF DECEASED _____	
19. ADDRESS OF PHYSICIAN _____		20. ADDRESS OF WITNESS _____	
21. ADDRESS OF DECEASED _____		22. ADDRESS OF PHYSICIAN _____	
23. ADDRESS OF WITNESS _____		24. ADDRESS OF DECEASED _____	
25. ADDRESS OF PHYSICIAN _____		26. ADDRESS OF WITNESS _____	
27. ADDRESS OF DECEASED _____		28. ADDRESS OF PHYSICIAN _____	
29. ADDRESS OF WITNESS _____		30. ADDRESS OF DECEASED _____	
31. ADDRESS OF PHYSICIAN _____		32. ADDRESS OF WITNESS _____	
33. ADDRESS OF DECEASED _____		34. ADDRESS OF PHYSICIAN _____	
35. ADDRESS OF WITNESS _____		36. ADDRESS OF DECEASED _____	
37. ADDRESS OF PHYSICIAN _____		38. ADDRESS OF WITNESS _____	
39. ADDRESS OF DECEASED _____		40. ADDRESS OF PHYSICIAN _____	
41. ADDRESS OF WITNESS _____		42. ADDRESS OF DECEASED _____	
43. ADDRESS OF PHYSICIAN _____		44. ADDRESS OF WITNESS _____	
45. ADDRESS OF DECEASED _____		46. ADDRESS OF PHYSICIAN _____	
47. ADDRESS OF WITNESS _____		48. ADDRESS OF DECEASED _____	
49. ADDRESS OF PHYSICIAN _____		50. ADDRESS OF WITNESS _____	
51. ADDRESS OF DECEASED _____		52. ADDRESS OF PHYSICIAN _____	
53. ADDRESS OF WITNESS _____		54. ADDRESS OF DECEASED _____	
55. ADDRESS OF PHYSICIAN _____		56. ADDRESS OF WITNESS _____	
57. ADDRESS OF DECEASED _____		58. ADDRESS OF PHYSICIAN _____	
59. ADDRESS OF WITNESS _____		60. ADDRESS OF DECEASED _____	
61. ADDRESS OF PHYSICIAN _____		62. ADDRESS OF WITNESS _____	
63. ADDRESS OF DECEASED _____		64. ADDRESS OF PHYSICIAN _____	
65. ADDRESS OF WITNESS _____		66. ADDRESS OF DECEASED _____	
67. ADDRESS OF PHYSICIAN _____		68. ADDRESS OF WITNESS _____	
69. ADDRESS OF DECEASED _____		70. ADDRESS OF PHYSICIAN _____	
71. ADDRESS OF WITNESS _____		72. ADDRESS OF DECEASED _____	
73. ADDRESS OF PHYSICIAN _____		74. ADDRESS OF WITNESS _____	
75. ADDRESS OF DECEASED _____		76. ADDRESS OF PHYSICIAN _____	
77. ADDRESS OF WITNESS _____		78. ADDRESS OF DECEASED _____	
79. ADDRESS OF PHYSICIAN _____		80. ADDRESS OF WITNESS _____	
81. ADDRESS OF DECEASED _____		82. ADDRESS OF PHYSICIAN _____	
83. ADDRESS OF WITNESS _____		84. ADDRESS OF DECEASED _____	
85. ADDRESS OF PHYSICIAN _____		86. ADDRESS OF WITNESS _____	
87. ADDRESS OF DECEASED _____		88. ADDRESS OF PHYSICIAN _____	
89. ADDRESS OF WITNESS _____		90. ADDRESS OF DECEASED _____	
91. ADDRESS OF PHYSICIAN _____		92. ADDRESS OF WITNESS _____	
93. ADDRESS OF DECEASED _____		94. ADDRESS OF PHYSICIAN _____	
95. ADDRESS OF WITNESS _____		96. ADDRESS OF DECEASED _____	
97. ADDRESS OF PHYSICIAN _____		98. ADDRESS OF WITNESS _____	
99. ADDRESS OF DECEASED _____		100. ADDRESS OF PHYSICIAN _____	

This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It is to be filed in the office of the State Department of Health, Baltimore, Maryland.



13146

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM OTTO White</u>		4. DATE OF DEATH Month Day Year <u>November 12 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1959</u>
9. AGE (In years last birthday) <u>0</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>0 0 13 15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Ernest White</u>		14. MOTHER'S MAIDEN NAME <u>Betty Lou Heinzelman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Wm. Ernest White (Father) 709 Smith St Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alelectasis</u> <u>762.5</u> DUE TO <u>Prematurity (1045 gms)</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/12</u> , 19 <u>59</u> to <u>11/12</u> , 19 <u>59</u> that I last saw the deceased alive on <u>11/12</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>11/13/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Alfred C. Kolls</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 14, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		24a. REC'D BY REGISTRAR <u>NOV 17 '59</u>	
ADDRESS <u>SALISBURY MARYLAND</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13145

13147

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>519 Rose Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Pete</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>About</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>E. O. The Washington</u>				Address <u>519 Rose St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure.</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic cardio-vascular disease.</u> Years DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH Hours. <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>4-16-59</u> , 19 <u>  </u> , to <u>11-25-59</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>11-25-59</u> , 19 <u>  </u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				ADDRESS (Street, city or town, state) <u>407 Camden Ave.</u>			
DATE SIGNED <u>12-1-59</u>							
PHYSICIAN'S NAME (Type) <u>Earl L. Royer, M.D.</u>				<u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/30/ 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton O. Stewart</u>				ADDRESS <u>Salis- Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>W. HARRISON WILLING</u>				4. DATE OF DEATH Month Day Year <u>Nov. 29 19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/4/1883</u>	9. AGE (In years last birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John W. Willing</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Willing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Mrs Kathleen Willing, Nanticoke, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 27</u> , 19 <u>59</u> , to <u>Nov. 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-29</u> , 19 <u>59</u> , and that death occurred at <u>3:15 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Elliot</u> M.D.				ADDRESS (Street, city or town, state) <u>Fal'sbury, Md.</u>			
DATE SIGNED <u>12-1-59</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Tyaskin, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messick</u>				ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>							

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CERTIFICATE OF DEATH

18181

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>		4. DATE OF BIRTH <b>1873</b>	
5. PLACE OF BIRTH <b>NEW YORK</b>		6. OCCUPATION <b>LABORER</b>		7. CAUSE OF DEATH <b>HEART DISEASE</b>		8. MANNER OF DEATH <b>NATURAL</b>	
9. PLACE OF DEATH <b>HOME</b>		10. TIME OF DEATH <b>10:00 AM</b>		11. DAY OF DEATH <b>10/15/1918</b>		12. MONTH OF DEATH <b>OCTOBER</b>	
13. YEAR OF DEATH <b>1918</b>		14. SIGNATURE OF DECEASED <b>[Signature]</b>		15. SIGNATURE OF WITNESS <b>[Signature]</b>		16. SIGNATURE OF PHYSICIAN <b>[Signature]</b>	
17. SIGNATURE OF REGISTRAR <b>[Signature]</b>		18. SIGNATURE OF CLERK <b>[Signature]</b>		19. SIGNATURE OF JUDGE <b>[Signature]</b>		20. SIGNATURE OF SHERIFF <b>[Signature]</b>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18